Health for Life CHIROPRACTIC
43059 Seven Mile Road· Northville, MI 48167 · 248.449.1630 · Fax 248.449.1558

CASE HISTORY

NAME_____DATE_____
ADDRESS_____CITY_____STATE_____ZIP_____
H. PHONE(____)_____W. PHONE(____)_____DATE OF BIRTH_____(AGE_____)
REFERRED BY_____SOCIAL SECURITY #_____
OCCUPATION_____EMPLOYER_____
MARITAL STATUS: S M D W SPOUSES NAME_____
SPOUSES OCCUPATION_____NUMBER OF CHILDREN & AGES_____
HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? _____YES _____NO

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health. This case history will uncover the layers of damage, especially to your nerve system, that result in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

LOSS OF WELLNESS

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

YES	NO		PATIENT COMMENT If answer is YES	CHIROPRACTOR'S Comments
		1.BIRTH PROCESS		
_____	_____	Did your mother experience any falls & injury's during pregnancy?	_____	_____
_____	_____	Was the delivery long?	_____	_____
_____	_____	Was the delivery difficult?	_____	_____
_____	_____	Forceps?	_____	_____
_____	_____	Cesarean?	_____	_____
_____	_____	Breach?	_____	_____
_____	_____	Home birth?	_____	_____
_____	_____	Hospital birth?	_____	_____
_____	_____	Mother given drugs during delivery?	_____	_____
_____	_____	Was labor induced?	_____	_____
		2. GROWTH AND DEVELOPMENT (BIRTH THROUGH TEENAGE YEARS)		
_____	_____	Were you taught how to care for your spine?	_____	_____
_____	_____	Did you fall out of bed?	_____	_____
_____	_____	Did you have childhood sickness?	_____	_____
_____	_____	Did you have accidents?	_____	_____
_____	_____	Did you have surgery?	_____	_____
_____	_____	Did you take drugs?	_____	_____
_____	_____	Did you experience child abuse?	_____	_____
_____	_____	Did you experience severe spanking?	_____	_____
_____	_____	Did you have your ear/chin pulled?	_____	_____

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_____	_____	Chair pulled out when sat down?	_____	_____
_____	_____	Did you fall down stairs?	_____	_____
_____	_____	Were you yanked by your arm?	_____	_____
_____	_____	Did you have other traumas?	_____	_____

YES	NO	3. LOSS OF WHOLE BODY HEALTH		
_____	_____	Did/ do you smoke?	_____	_____
_____	_____	Did/ do you drink any alcohol?	_____	_____
_____	_____	Do you eat healthy foods?	_____	_____
_____	_____	Do you exercise regularly?	_____	_____
_____	_____	Have you had surgery & organs removed/ replaced?	_____	_____
_____	_____	Did/ do you take drugs prescriptive or non-prescriptive?	_____	_____
_____	_____	Did/ do you have occupational stress?	_____	_____
_____	_____	Did/ do you have physical stress?	_____	_____
_____	_____	Did/ do you have mental stress?	_____	_____
_____	_____	Did/ do you have sports injuries?	_____	_____

PRIMARY REASON FOR CONSULTING OFFICE

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present complaint_____
Pain or problem started on_____
Pains are: _____SHARP _____DULL _____CONSTANT _____INTERMITTENT
Intensity: _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10
Frequency: _____Daily _____2-3 times weekly _____Sporatic
Is this condition worse at certain times of the day? ___Morning ___Afternoon ___Evening ___During sleep
Is this condition interfering with work?_____ sleep?_____ routine?_____ other?_____
Is this condition getting progressively worse?_____ Other doctors seen for this_____
Are you using any home remedies?_____

OTHER SYMPTOMS:

_____HEADACHES	_____PINS & NEEDLES IN LEGS	_____LOSS OF SMELL
_____NECK PAIN	_____NUMBNESS IN FINGERS	_____LOSS OF TASTE
_____SLEEPING PROBLEMS	_____NUMBNESS IN TOES	_____DIARRHEA
_____BACK PAIN	_____SHORTNESS OF BREATH	_____FEET COLD
_____NERVOUSNESS	_____FATIGUE	_____HANDS COLD
_____TENSION	_____DEPRESSION	_____STOMACH UPSET
_____IRRITABILITY	_____LIGHTS BOTHER EYES	_____CONSTIPATION
_____CHEST PAINS	_____LOSS OF MEMORY	_____COLD SWEATS
_____DIZZINESS	_____EARS RING	_____LOSS OF BALANCE
_____FACE FLUSHED	_____FEVER	_____BUZZING IN EARS
_____NECK STIFF	_____FAINTING	_____OTHER SYMPTOMS

Have you been under medical care recently or for this problem?_____
Have you been taking prescriptive or non-prescriptive drugs_____
Have you had surgery?_____Any side effects from drugs or surgery?_____
Is there a family history of:

	HEART DISEASE	ARTHRITIS	CANCER	DIABETES	OTHER
Fathers side	_____	_____	_____	_____	_____
Mothers side	_____	_____	_____	_____	_____